MADRAS MEDICAL COLLEGE AND

RESEARCH INSTITUTE

CHENNAI

PSYCHOLOGY CASE RECORD

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in partial fulfillment of the requirements for

DPM Final Examination

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Submitted by

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BONAFIDE CERTIFICATE

This is to certify that this is bonafide record of the work done by **Dr. M. LIDWIN MARY** in partial fulfillment of the requirement for the **DPM Final Examination** of the Tamil Nadu Dr. M.G.R. Medical University during the period June 2009 – April 2011.

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CASE I

Name	:	Mr. J.
Age	:	60 years
Sex	:	Male
Marital Status	:	Married
Religion	:	Christian
Education	:	12th Std
Socio Economic	:	LSES
Informants	:	Daughters
Information	:	Adequate, consistent and Reliable

REASONS FOR CONSULTATION

1. Memory Disturbance — for 6 months
2. Poor Self Care — ↑ 3 months
3. Sleep Disturbance — ↑ 3 months

Insidious onset, Progressive course, No obvious precipitating factors Ist psychiatric consultation.

HISTORY OF PRESENT ILLNESS

According to the informants the patient was reported to be normal till 6 months back. Then, his elder daughter noticed that the patient repeatedly searched for certain common things in the house. He would forget simple things in the house like the way for going to toilet.

At times he also found it difficult to return to his house after going for a walk Gradually, he was unable to identify his close relatives and called his daughter as his sister. And also he was not able to remember whether he had taken his food or not.

His self care decreased gradually for 6 months. Now for 3 months, he did not take bath and did not change the dress. At times, he would pass urine inside the house.

He was found to have disturbed sleep. He slept for very little time, and would wake up in the middle of the night and keep pacing inside the house.

No H/o persistent depressed or elated mood.

No H/o. sucidal ideas or attempts

No H/o repetitive thoughts/acts

PAST HISTORY

No similar illness before

No H/o any head injury. Seizure or fever

No H/o hypertension or Diabetes mellitus

No H/o substance abuse

FAMILY HISTORY

Born of consanguineous marriage 1st in order of 5 siblings

No H/o any mental illness/suicide or missing members in the family.

PERSONAL HISTORY

Full term, normal delivery, Developmental milestones were normal.

Studied upto 12^{th} std.

Married at the age of 28 years, No H/o marital disharmony and has 3 children.

PERSONALITY TRAITS

Calm in nature

Adjustable

Tolerate to criticism

Responsible and affectionate

Sociable

Highly religious

He was able to do simple mathematical work and handled money and financial matters without other's help.

PHYSICAL EXAMINATION

Thin built, not anemic, not jaundiced, no pedal edema

Pulse 70/mt

BP – 120 / 80mm Hg

CVS – S1 S2 heard

RS – NVBS heard

Abdomen – Soft, non tender, no organomegaly

CNS – Clinically normal

Fundus - Normal

MENTAL STATUS EXAMINATION

General appearance and behaviour

Patient was brought to the interview room by his daughter conscious, ambulant neatly dressed.

Attitude

Not co-operative for interview

Gaze contact was made

Rapport established with difficulty.

Psychomotor Activity

Increased, no tics or mannerisms

Talk

He was not communicable answered in monosyllables after asking simple questions that too repeatedly.

Emotions

Mood : Euthymic

Affect : Restless and irritable

Thought

No delusions

Perception

No perceptual disturbances

OTHER COGNITIVE FUNCTIONS

Not oriented to time and place

Oriented to person

Attention aroused with difficulty

Concentration imparied

Digit forward 2

Digit backward 0

Memory

Recent/remote and immediate memory are impaired.

Intelligence, abstraction and judgment impaired.

Insight : Absent

PROVISIONAL DIAGNOSIS

F 00 Dementia in Alzheimer's disease.

PSYCHOLOGICAL ASSESSMENT

Mr. J. who was provisionally diagnosed as a case of dementia is taken up for psychological testing to establish the diagnosis and to assess the severity of illness.

TESTS ADMINISTERED AND THEIR RATIONALE:

1. **Mini Mental Status Examination** (MMSE) - It is a screening test to identify the organic etiology and also to assess the course of illness.

2. **Wechsler Memory Scale** - Used to assess his memory functions.

3. **Bender Gestalt test** - Used to assess the perceptual visuomotor functions

4. **Brief Psychiatric Rating Scale** - Used to assess associated psychiatric problems.

5. **Seguinform board test** - A form perception test and also used as a test of intelligence.

6. **Dementia Rating Scale** - Used to assess the severity of dementia.

BEHAVIORAL OBSERVATION:

The patient was made to sit in the chair by his daughter and he frequently try to go out during the interview. He was very much irritable and not cooperative for examination. Questions had to be repeated many times to get an answer.

TEST RESULTS

He obtained a very low score of 9 out of 30 in mini mental status examination showing a severe degree of impairment. In Wechsler memory scale, he was not able to answer the questions because of poor concentration and

on repeated questioning he answered irrelevantly. He was not able to draw a figure properly in Bender Gestalt test He simply scribbled over a paper which showed the organic nature of the disease and visuo motor disturbance.

Brief psychiatric rating scale revealed his uncooperativeness, psychomotor agitation, inappropriate affect and disorientation to time and place all of which showed an organic nature and major psychiatric symptoms such as delusions and hallucinations were not present.

He could not perform Seguin form board test and he even could not understand the way to perform the test. Dementia rating scale revealed his inability to perform household tasks, inability to find ways, inability to recall recent events, dressing without buttons, purposeless hyperactivity and diminished emotional responsiveness all of which indicates a severe degree of impairment.

SUMMARY

There is marked impairment in his cognitive functions and visuo spatial perception. There is also deterioration in personal hygiene and personality.

FINAL DIAGNOSIS

F00 - Dementia in Alzheimer's disease

MANAGEMENT: PHARMACOLOGICAL:

Cholinesterase inhibitors are useful. They potentiate the cholinergic neurotransmitter. Very low doses of antipsychotics for behavioral problems.

BEHAVIORAL:

Family counseling to provide awareness to the family members about the guarded prognosis for this patient and the importance of rehabilitation.

Relatives were advised to give an understanding atmosphere to the patient and help him not to get confused.

Importance of proper follow-up is stressed to monitor the condition of patient and to help the family members in dealing with the patient adequately.

CASE II

Name	:	Mr. A.
Age	:	40 years
Sex	:	Male
Marital Status	:	Married
Occupation	:	Car Driver
Education	:	5^{th} Std
Socio Economic	:	LSCS
Informants	:	Wife
Information	:	Adequate, consistent and Reliable

REASONS FOR CONSULTATION :

Consumption of Alcohol	-	Past 10 yrs
Increased frequency and quantity	-	Past 5 yrs
Sleep disturbance	-	1 month

HISTORY OF PRESENT ILLNESS :

The patient was reported to be normal 10 years back. Started to consume alcohol 10 yrs back along with his friends for pleasure, he gradually increases frequency as well as quantity over the time.

For the past 5 yrs he used to have almost daily and start to have early in the morning, as he spent most of the money for alcohol and frequent absent in work caused decreased productivity.

Because of that he had frequent interpersonal problem with his wife. For last 5 days for the concern of the family and concern with his physical condition he stopped consuming alcohol. He had sleeplessness since then.

No H/o symptoms suggestive of psychotic features

No H/o inflated self esteem / elated mood

No H/o withdrawal seizures / suicide attempt

No H/o head injury / fever

No H/o hemetemesis / melena / abdominal pain

PAST HISTORY:

History of jaundice before 10 yrs

No history of HT/DM

No history of other substance use.

FAMILY HISTORY

Born of non consanguineous parents

Ist in order of 2 siblings

Family H/o alcoholism – in his father and two elder brothers

No H/o any mental illness / suicidal attempts in his family.

PERSONAL HISTORY

Birth and milestones – normal

Joined school at the age 5. Regular to school Average in studies. Interaction with peer groups were normal

Married at the age of 25 years. Having 1 daughter and 3 sons.

PREMORBID PERSONALITY

Adjustable and easy going

Tolerant to criticism, responsible

He was interested in music and playing ring balls.

PHYSICAL EXAMINATION

Thin built, Conscious

not anemic, not jaundiced

No pedal edema

Febrile

PR – 72/mt

BP-110/80 mm Hg

CVS-SI, S2 heard.

RS – NVBS (+) No added sounds

Abdomen - Soft, No organomegaly

CNS - Clinically normal.

MENTAL STATUS EXAMINATION:

General Appearance and Behavior:

Conscious, ambulant,

Attitude

Dressed adequately and neatly

Co- operative for Interview,

In touch with surroundings

Rapport established,

Psychomotor Activity - normal.

No Abnormal / movements

Tremors on outstretched hands (+)

Speech

Relevant and coherent

Quantum, tone and rate – normal

Reaction time normal

No dysarthria / stammering / stuttering

Emotion

Mood : (s) Feels good

(o) Reactive, appropriate , No ability

Thought

No delusions

Perception

No perceptual disturbances

PRIMARY MENTAL FUNCTIONS

Attention	:	Arousable
Concentration	:	Sustained
Orientation	:	Oriented to time, Place, person
Memory	:	Immediate, Recent, remote intact
Intelligence	:	Average
Abstract thinking	:	Intact
Judgement	:	Intact
Insight	:	Trace emotional insight

PROVISIONAL DIAGNOSIS:

F10- Mental and Behavioral disorder due to an Alcohol.

PSYCHOLOGICAL ASSESSMENT:

Mr. A, who was provisionally diagnosed as a case of Mental and behavioral disorder due to an alcohol and he is taken up for psychological testing to establish the diagnosis and to assess the motivation and risk for relapse.

TESTS ADMINISTERED AND THEIR RATIONALE:

1. **CAGE questionnaire** - It is a screening test to identify the alcoholic abuse.

2. **Michigan alcohol screening test (MAST)** - Used to assess alcohol use and Alcohol related disabilities.

3. **Inventory of drug taking situations (IDTS)** - Used to assess situations which trigger heavy drinking and used to better understand relapse episodes in Individuals.

BEHAVIORAL OBSERVATION:

The patient is co operative and discloses information enthusiastically.

TEST RESULTS:

In CAGE questionnaire reveals that he was dependant on alcohol, guilt about his drinking, easily annoyed by people, unable to cut down his drinking.

In MAST reveals that he had many alcoholic response and diagnosed as Alcoholism.

On IDTS he drank heavily when he was depressed about things in general, he felt shaky, sick or nervous and when he had trouble sleeping and to relieve somatic pain.

SUMMARY:

He is suffered from alcohol dependence syndrome, and has good motivation.

FINAL DIAGNOSIS:

F10. Mental and Behavioural Disorder due to use of Alcohol.

Flx.2 Dependence syndrome

F.20 Currently abstinent.

MANAGEMENT: PHARMACOLOGICAL:

Treatment of the medical illness

Detoxification

Benzodiazepines - diazepam 5 mg HS

FAMILY COUNSELLING:

Family counseling to provide awareness to the family members about the risk of the relapse, family members must learn not to protect the patient from the problem caused by alcohol.

Otherwise the patient may not be able to gather the energy and motivation necessary to stop the alcohol.

Importance of follow-up is stressed to monitor the condition of patient and to help the family members in dealing with the patient adequately.

REHABILITATION:

Continued effort to increase and maintain high levels of motivation for Abstinence.

Work to help the patient readjust to a lifestyle free of alcohol.

Relapse prevention.

SELF HELP GROUPS :

Members of AA have help available 24 hours a day, associate with a sober peer group, learn that it is possible participate in the social functions without drinking, and are given a model of recovery by observing the accomplishments of sober members of the groups.

CASE III

Name	:	Mr. M
Age	:	35 years
Sex	:	Male
Marital Status	:	Married
Occupation	:	Carpenter
Religion	:	Muslim
Education	:	5^{th} Std
Informants	:	Wife
Information	:	Adequate, consistent and Reliable

PRESENTING COMPLAINTS

1. Dull and withdrawn behaviour suspiciousness — 3 years
2. Not going for the job — ↑ for 6 months
3. Decreased self care/talking to self — 1 year
4. Sleeplessness — 6 month

Mr. M. got married 4 years ago, was normal upto 1 year after marriage. Working as a carpenter and interacting well with others. Gradually he became dull and was found irregular in his work. He became less communicative and was pre occupied. He did not give any proper reply for his behavioural changes, when questioned by his wife.

Gradually he started suspecting that his neighbours are talking ill about him and monitoring his daily activities secretly and also they are trying to do harm against him by doing black magic. He picked up quarrel with his neighbours for the same. He would also abuse and at times even assault his neighbours.

He started refusing food at his relative's house suspecting it to have been mixed with poison. Stopped going for job. His self care gradually decreased. He took bath and brushed his teeth only on compulsion by his wife.

Gradually, he began to talk alone for one year. He started having sleep disturbance for 6 months, had difficulty in initiation as well as maintenance of sleep. His appetite decreased and did not take food in adequate amount.

Initially, he was taken for magico-religious treatment and since there was no improvement, he was taken to a private psychiatrist at Madurai and prescribed drugs. He was on irregular treatment since then. The symptoms improved to some extent. His sleep and self case improved. Suspicious ideas decreased.

For the past 2 months the symptoms aggravated, his suspiciousness increased. He also started suspecting that his wife killed his son and daughter. He slept hardly for 2-3 hours per day. He was showing hostility towards his wife and once tried to slab her wife a scissors.

No H/o persistent depressed or elated mood

No H/o repetitive thoughts and acts

No H/o suicidal ideas or attempts

No H/o head injury / LOC /Seizure / Fever

No H/o substance abuse

PAST HISTORY

No H/o significant psychiatric or medical illness.

FAMILY HISTORY

Born of Non-consanguineous marriage

Ist in birth order of 4 siblings

H/o mental illness in younger sister, suggestive of schizophrenia

No H/o any abscondings / wanderings.

PERSONAL HISTORY

Full term, normal delivery

Developmental milestones were normal

Studied up to III standard

Above average in studies.

Married at the age of 31, no H/o marital harmony

Having 2 children

1 Male both alive

1 Female and healthy.

PREMORBID PERSONALITY

Conscious, afebrile, not anemic, not jaundiced, No pedal edema, No clubbing, PR – 72/ml, BP – 110 / 70 mm Hg, CVS - S1, S2 heard, no murmur.

RS - NVBS : No added sounds

No organomegaly

CNS : Clinically Normal

Ocular Fundi : Normal

MENTAL STATUS EXAMINATION

General appearance and behaivour

Conscious, Ambulant, Dressed adequately.

Attitude

Co Operative, in touch with surroundings

Gaze contact was made

Rapport established

Pscychomotor activity

Normal ; No abnormal movements

Speech

No spontaneous talk

Relevant and coherent

Quantum , Zone, rate, normal

Reaction time – normal

Mood

(S) - Feels good

(obj) - Restricted, No lability

Thought

Form Stream – Normal

Content

Delusion of reference

Delusion of persecution

Perception

Fleeting 2nd person auditory Hallucination (+)

Primary mental functions

Attention	-	Aroused
Concentration	-	Ill sustained
Orientation	-	Oriented to time, place, person
Memory	-	Immediate, Recent and Remote – intact
Intelligence	-	Average
Judgement	-	Hypothetical situation – intact
		Personal judgement – impaired
Insight	-	Grade I (Denies illness)

Diagnostic formulation

35 years old married male presenting with 3 years duration of suspiciousness, decreased self care, and sleep disturbance, H/o Mental illness, in younger sister suggestive of Schizophrenia premorbidly ambiverted, physically normal, MSE – revealing normal PMA, Relevant talk, Delusion of reference and delusion of persecution, fleeting 2nd person auditory hallucination, restricted affect, impaired personal judgment and grade I insight.

Provisional diagnosis

ICD 10 : F.20.0 Paranoid schizophrenia.

INVESTIGATIONS

Blood

Hemogram	-	Normal
Sugar (R)	-	110 mgs / dl
Urea	-	29 mgs %
Creatinine	-	0.9 mg %
VDRL	-	Non reactive
LFT	-	Normal
Serum Cholesterol	-	Normal
ECG	-	WNL
X-ray Chest	-	Normal
CT Scan Brain (P)	-	Normal study
EEG	-	Normal study

PSYCHOLOGICAL ASSESSMENT

This married male, provisionally diagnosed as paranoid schizophrenia was assessed with following psychological tests.

1. Symptom Sign Inventory (SSI)

To asses symptom loading on various diagnostic categories.

2. Sentence Completion Test (SCT)

A Semi projective test to assess the interpersonal problems, attitudes towards significant offers in his life, goals and conflicts.

3. Thematic Apperception Test (TAT)

A projective test of personality used to assess her interpersonal relationship, goals and conflicts.

4. Brief Psychiatric Rating Scale (BPRS)

To rate his psychiatric symptoms

5. Rorschach's Inkblot Test

A projective test of personality used to assess his personality structure and diagnosis.

6. Positive And Negative Syndrome Scale (PANSS)

Was given to assess the severity of psychotic symptoms.

BEHAVIOURAL OBSERVATION

He is cooperative for testing, but had a monotonus talk with paranoid content and talked about getting out of the hospital.

TEST RESULTS

He had significant paranoid and schizophrenic symptoms as seen from SSI. Some of the paranoid symptoms scored are others talking of him, criticizing him, harming him, trying to poison him, making him feel sick,

plotting against him. He also believes that others are talking ill of his behind the scene and are targeting his brain and heart to function badly. He believes that others regard him odd. He also says that neighbours are trying to spoil his name.

SCT

Reveals that he has positive attitude toward his family but negative attitudes towards his neighbours. He is highly insecure and full of paranoid ideations is extremely worried about his character and is full of suspiciousness about people around him.

He has ambivalent feeling towards various issues and his statements are vague on various occasion. He has projected his thoughts on sexual promiscuity.

TAT

Stories were of average length Content reveals poor family background, sadness due to various family problems, ill treatment of others, her fear of being looked down by others. He has projected his thoughts by saying that some neighbours making sexual advances towards him. He also projected his paranoid perception in his environment.

RORSCHACH

He is shaky in his concepts and is not very confident either in giving his responses or in giving the determinants. He has average mentation and high

aspiration with limited circumstances to back them up. Contents reveal some paranoid and schizophrenic features.

BPRS

Poor eye contact, syspiciousness, hallucinations thought disturbances indicating moderate to severe degree of psychosis.

PANSS

Brought out significant positive symptoms in the form of auditory hallucination, marked persecutory delusions of reference and paranoid and persecutory delusions.

SUMMARY

He has first rank symptoms and prominent schizophrenia symptoms as indicated by various tests. So, this case is diagnosed to be a case of Paranoid Schizophrenia.

FINAL DIAGNOSIS

F 20.0 Paranoid Schizophrenia.

MANAGEMENT

Pharamacotherapy

Patient is on	T. Risperidone	2mg	1 - 0 - 1
	T. Trihexyphenidyl	2 mg	1 - 0 - 0
	T. Lorazepam	2mg	0 - 0 - 1

PSYCHOLOGICAL

At present, supportive psychotherapy will be helpful. After the decrease in psychotic symptoms, psycho educating him about the illness and cognitive behaviour therapy can be applied.

The family members have to be educated about the course and outcome of the illness. The importance of Drug compliance has to be stressed.

CASE - IV

Name	:	Mrs. N
Age	:	30 years
Sex	:	Female
Marital Status	:	Married
Occupation	:	Housewife
Religion	:	Christian
Education	:	B.A.
Informants	:	Self, Mother
Information	:	Adequate, consistent and Reliable
Socio economic	:	LSES

PRESENTING COMPLAINTS

1. Repeated thoughts that her hands are contaminated followed by compulsive acts of frequent washing and cleaning — 6 yrs ↑ 6 months

2. Feeling sad
3. Sleep disturbances

} 6 months

HISTORY OF PRESENT ILLNESS

Mrs. N was reported to be normal 6 years back, working as a tailor and taking care of her family. Gradually, she started to think that her hands were contaminated and she started washing her hands very frequently. She started to worry about her routines and started to wash repeatedly all her households like

utensils, clothes, floor, household items and used to take bath for long hours to keep herself clean.

The thoughts of cleanliness occurred repeatedly as intrusive ones in her mind and got partial satisfaction only after performing these acts. The patient recognised the thoughts were her own, initially the thoughts were minimal and gradually, it started increasing. She tried to cut down the thoughts but she cannot. So she became anxious. This also resulted in disturbances in her work time, resulting in absenteeism and she was left feeling helpless over this issue.

She kept doubting about matters like whether she had locked the door, switched off the lights and would keep checking repeatedly even though she felt it was excessive.

The symptoms were increased for the past 6 months, and she started getting such thoughts most of the time. This made her very much distressed and her work performance decreased. She started feeling sad. She had sleep disturbance. She had difficulty in initiation of the sleep. At times, she had suicidal thoughts, but no attempts was made.

No H/o. other repetitive thoughts / images / impulses

No H/o. suspiciousness (or) hearing voices

No H/o. seizure / head injury

PAST HISTORY

No significant medical or psychiatric illness in the past.

FAMILY HISTORY

Born of non consanguineous marriage

3rd of 5 siblings

History of similar illness in her paternal uncle

No H/o psychotic illness / suicide / substances abuse

PERSONAL HISTORY

Birth and milestones were normal

Educated and employed

Menarche by 13 years; Regular menstrual periods.

Married at 20 years of age; No marital disharmony has I children - healthy.

PERSONALITY TRAITS

extravert

had many friends

religious

perfectionist

meticulous in her activities

enjoyed gardening and reading books.

PHYSICAL EXAMINATION

Alert

Ambulant

BP - 120 / 70 mmHg

PR - 80 / mt

CVS - S_1S_2 heard

RS - NVBS heard

Abdomen - soft, non tender, no organomegaly

CNS - Clinically normal

Fundus - Normal

MENTAL STATUS EXAMINATION

General / Appearance and Behaviour

Alert, in touch with surroundings well kempt, dressed adequately.

Rapport was established

Gaze contact made and maintained

Psychomotor activity within normal limits.

Talk - relevant and coherent

quantum, rate and tone - normal

reaction time normal

Emotions

Mood - Anxious

Affect - Anxious, appropriate

- No lability

Thought

Form, Stream - Normal

Content - No delusions

- No referential ideas

- Ideas of helplessness

Possession

Obsessive thoughts of contamination and washing compulsions.

Perception

No perceptual disturbances.

Primary Mental Functions

Attention - Aroused

Concentration - Well sustained

Digit Forward - 5

Digit Backward - 4

Orientation - Oriented to time, place and person

Memory - Immediate, Recent, Remote } Intact

Intelligence - Average

General fund of information - Adequate

Abstract thinking intact

Judgement	-	intact
Insight	-	Carade VI
		Tree emotional insight

DIAGNOSTIC FORMULATION

30 years old female presenting with complaints of repeated thoughts that her hands are contaminated, frequent washing and cleaning, apprehension and unpleasant repeated intrusive thoughts encompassing her occupation. With family H/o similar illness in her paternal uncle. Premorbidly - extraverted, physically normal MSE - revealing normal PMA, relevant and coherent talk, anxious mood with obsessions and compulsions; no perceptual disturbances. Intact primary mental functions with grade VI insight.

PROVISIONAL DIAGNOSIS

ICD - 10

F 42.2 obsessive compulsive disorder - mixed obsessional thoughts and acts.

INVESTIGATIONS

Blood

Hemogram	-	WNL
Sugar (R)	-	120 mg/dl
Sr. Cholesterol	-	Normal
Renal function test	-	Normal
Liver function test	-	Normal

ECG	-	Normal
X-ray chest	-	Normal
CT Scan brain	-	Normal study
EEG	-	Normal study

PSYCHOLOGICAL ASSESSMENT

Tests administered and their rationale

1. **Eysenck's Personality Questionnaire :** It is used to assess the different dimensions of her personality

2. **Sentence Completion Test :** was used to elaborate on her attitude towards family, parents and her interpersonal relationships.

3. **Thematic Apperception Test** : A projective test of personality used to assess her interpersonal relationship, goals and conflicts.

4. **Rorschach Test** : a projective test of personality used to assess her personality structure and diagnosis.

5. **Hamilton Anxiety Rating Scale** : is used to assess the severity of anxiety.

6. **Yale Brown Obsessive Compulsive Scale** : It is used to rate the severity of obsessive and compulsive symptoms.

7. **Hamilton Rating Scale for Depression** : used to estimate the level of depression.

BEHAVIOURAL OBSERVATIONS DURING TESTING

Rapport could be established easily. She came out with her problems by herself. She was cooperative and regular to the sessions.

TEST RESULTS

Eysenck's personality questionnaire.

Her scores indicate severe degree of neuroticism with low psychoticism and moderate extraversion.

SENTENCE COMPLETION TEST

She has positive feelings towards friends, superiors, teachers, marriage and women in general. She has negative feelings towards her father. She showed feeling of inferiority and high sensitivity, longing for affection from others. She is apprehensive about minor conflicts.

THEMATIC APPERCEPTION TEST

Her stories are productive, imaginative and projective of her childhood experience as a neglected child. Her parents had highly conflicting attachments which had resulted in her fears and conflicts about marriage and sex. She is also highly neurotic with fears of darkness and loneliness.

RORSCHACH TEST

Her responses reveal that she is highly imaginative which at times leads to unwanted thoughts, preoccupations and emotional reactions. She has highly disturbed personality with highly critical attitude which even amounts to paranoid ideations. She has adequate ego strength inspite of neurotic fears which favours the receptivity of psychotherapeutic interventions.

RATING SCALES

Reveal mixed symptoms of obsessions and compulsions with features of anxiety and a certain amount of depression due to life stressors.

SUMMARY

She scored high on various neurotic dimensions on personality indicating that she is highly neurotic in her thoughts, feelings and reactions to the environment with which we can diagnose her as a case of mixed neurosis with obsessive symptoms.

FINAL DIAGNOSIS

F 42.2 obsessive compulsive disorder, mixed obsessional thoughts and acts.

MANAGEMENT

Pharmacological	-	T. clomipramine	25 mg	1 - 0 - 1
		T. clonazepam	0.5 mg	0 - 0 - 1

PSYCHOTHERAPY

Cognitive behavioural therapy to change and modify irrational thoughts.

Exposure and response prevention to manage the compulsions.

Thought stopping to manage the obsessions

As she has high dependency needs and insecurity, she was treated with supportive psychotherapy. Behaviour counseling is also undertaken. Family therapy is of utmost importance and occupational rehabilitation is also a part of therapy.

CASE - V

Name	:	Mr. B
Age	:	36 years
Sex	:	Male
Marital Status	:	Unmarried
Occupation	:	Unemployed
Religion	:	Hindu
Education	:	12th Std.
Informants	:	Mother
Information	:	Adequate, consistent and Reliable
Socio economic	:	LSES

REASONS FOR CONSULTATION

1.	Excessive fear of closed space, travelling in crowded bus and going to crowded places	
2.	Excessive concern of the world	3 years
3.	Not going for job	
4.	Refusing marriage	
5.	Sleep disturbance	2 years
	Sudden onset	
	Continuous, Progressive illness	

HISTORY OF PRESENT ILLNESS

Mrs. B was reported to be normal 3 years back, working in a Tasmac Shop. One day, he was travelling with his friend in a car; and his friend got out of the car in order to take cash out of the ATM and locked him in the car.

About 5 minutes later, the patient experienced palpitation, sweating and trembling of hands, breathlessness and fear that something untoward may happen to him and wanted to get out of the car at once. He felt better after 5-10 minutes, when he came out of the car.

Two months later, when he was travelling with the same friend, he experienced similar episode. After this incident he avoided travelling by cars. After that, he started feeling uncomfortable in other closed spaces, and also he was unable to travel in lifts, in government buses with automatic doors. Whenever he faces this situations, he experienced fear, and this fear would last for 5-10 minutes. He also experienced similar fear for heights and speaking in the public places.

He also been persistantly worried, whenever he sees any unpleasant events or hear or watch bad news in TV, he began to think about atrocities occurring in the country like crime, rape, murder, kindnapping, bribery, poverty, famine and draught.

He spent most of his time thinking about this. He keeps contemplating about his existence about who is he, what his role in the world.

He has not been going for work for 3 years and he is not having confident of doing his job well and that fear and tremors disabled him from doing a job, and he also feels afraid of his superiors at work.

When his mother asked him to get married he wished to have a guarantee that his mind and body is healthy and that of his wife must be certified as healthy.

He has also been experiencing difficulties in going off to sleep, as he worries if some harm may befall on him, when he is asleep like earthquakes.

He gets sleep after 2-3 hours and sleeps upto 7-8 am a day. All of these complaints have been present most of the time for the past 3 years.

Since he had not seen going for work and refusing marriage his mother brought him to IMH for consultation.

No H/o. talking / laughing to self.

No H/o. abusive / assaultive behaviour

No H/o. inflated self esteem.

No H/o. suspiciousness / hearing voices

No H/o. elated mood / sad mood

No H/o. repetitive thoughts / intrusive images

No H/o. seizuer / LOC / fever

PAST HISTORY

No H/o. any psychiatric illness in the past

No H/o. any surgeries

No H/o HT / DM

FAMILY HISTORY

Born of non consanguineous marriage

4th among 4 siblings

H/o mental illness in his father.

Grand father / his sister present

H/o. Alcohol dependence present in his elder brother / uncle

H/o. Suicide in his uncle's son

PERSONAL HISTORY

Birth and milestones were normal

Started Schooling at the age of 5.

Not regular; Below average in studies.

Initially at the age of 18 years - working as a Tailor - 10 yrs.

Currently unemployed

No H/o any substance abuse.

PREMORBID PERSONALITY

Had limited friends

Not able to maintain relationships

Affectionate, responsible towards family members, worrier person, concerned about order and symmetry. Used to check the lock 4-5 times and he used to count money 3-4 times.

PHYSICAL EXAMINATION

Conscious

Moderately built

Not anemic

Not jaundices

No cyanosis

No clubbing / No generalised lymphadenopathy

Afebrile

PR - 78 / mt ; Bp - 110 / 70 mm Hg

Tremors of both lands (+)

Thyroid not enlarged

All systems - within normal limits

CVS - S1S2(+)

RS - NVBS

CNS - No neurological deficit

Abdomen - Soft

No organomegaly

Bilateral Fundi - Normal

MENTAL STATUS EXAMINATION

General / Appearance and Behaviour

Conscious, ambulant. In touch with surroundings, dressed adequately, well kempt. Rapport could be established.

PMA - Normal

Speech - Spontaneous excess talks (+)

qtr ↑ ; rt ↓

Relevant, Coherent

Prosody of speech (+)

Emotion

Mood - Anxious

Affect - Anxious, appropriate, reactive

Thought

Form	-	Tangentiality
Stream	-	Increased
Content	-	Claustrophobia, oncholophobia, acrophobia, astraphobia, mysophobia, pathophobia.

Perception

No perceptual disturbances.

PRIMARY MENTAL FUNCTIONS

Attention was aroused, sustained

Oriented to time, place and person

Memory	-	Immediate, recent, remote - intact
General information	-	average
Abstraction	-	intact
Judgement	-	Intact
Grade V	-	Insight

INVESTIGATIONS

Complete hemogram, S. electrolytes, S.calcium, thyroid function tests, renal function tests - within normal limits.

X-ray chest, ECG, USG - Abdomen, Normal Study, EEG, CT Scan brain - Normal study.

DIAGNOSTIC FORMULATION

A 30 years old unmarried male from an urban background has been brought by his mother with C/o. 3 years duration of sudden onset of fear of closed space, travelling in crowded bus and going to crowded places, excessive concern about himself and the world, not going for job, refusing marriage. Sleep disturbance for 2 years, with family History of mental illness in his father, paternal grand father and his elder sister, family H/o alcohol dependence in his elder brother and uncle H/o suicide in uncle's son; personal history of truancy at 9, 10 yrs of age, tried to strangulate himself at 10 yrs of age; on physical examination, tremors of both hands present. MSE - revealing an alert male with good rapport. Normal motor activity, spontaneous excessive speech. Increased (Quantum, tone, rate of speech. Thought - Form - Tangentiality, stream - increased content - fear of closed space, travel in lifts, closed and crowded buses, going crowded places, fear of heights and fear of speaking in public.

Mood - Anxious, Appropriate affect, No perceptual disturbance. Intact - Higher mental function. Grade V insight.

PROVISIONAL DIAGNOSIS

ICD - 10

F 40 - Phobic Anxiety disorder

F 40.01 with panic disorder.

PSYCHOLOGICAL ASSESSMENT

Mr. B is a case of phobic Anxiety disorder. He is assessed for his personality, psychology and conformation of diagnosis.

Tests administered and their rationale

1. **Bender Gestalt's test (BGT) :** for visuo-perceptual function.

2. **Eysenck Personality Questionnaire (EPQ) :** to assess personality

3. **Sentence Competition Test** : to assess the interpersonal problems, attitudes towards significant others in his life, goals and conflicts.

4. **Symptom Sign Inventory and Middlesex Hospital Questionnaire** : to quantity various dimensions like anxiety and depression.

5. **State Trait Anxiety Inventory** : to assess anxiety levels.

6. **Social anxiety Scales :** to assess social anxiety.

7. **Hamilton Rating scale for Depression** : to assess depression severity.

8. **Rorschac ink blot test** : a project test of personality.

Test Findings

BGT shows good visuo - perceptual function on EPQ - there is a significant Neurotic traits in the individuals.

Patient was screened on IPDE which shows a positive indication towards anankastic and anxious, sohizoid on sentence completion test.

There is no significant conflict except in the sexual area, feels extremely guilty for masturbation.

Diagnostics

SSI & MHQ shows significant elevation on anxiety and depression.

However on HAM-D, the score is 5 which suggest no depression.

On state and Trait Anxiety - the scores are not significant enough.

On Fear Evaluation

There is a marked amount of fear institutions like - walking alone in busy streets and also avoids it. Being watched or starred at, going into crowded shops, fear of going alone - far away from home and also he tries to avoid these situations. Fear of thought of injury or illness is also in severe grade noted.

Social Anxiety Seats Shows

Severe amount of anxiety, drinking with others in public places, acting or performing in front of an audience, working while being observed, entering the room. When others already seated, speaking up in a meeting, and he avoids these situations. Has a difficulty in organizing a function at home mild to moderate amount of anxiety experienced in going to parties, weddings, talking to people whom he do not know very well. However he does not avoid these situation.

He has fear of urinating in public bathrooms, due to the fear that he may get an infection or disease and also avoids it.

On Rorsach's Ink Blot Test

Patient gives a total response of 10 with average mentation time. Patient has given four popular response with six originals with medico form level rating, content analysis shows animals and human responses.

BEHAVIOURAL OBSERVATION

He was cooperative for testing, eye contact maintained, rapport established, talk - relevant and coherent, Attention could be aroused and sustained, able to comprehend instructions.

SUMMARY

Patient with cognitive functions with evidence of anxiety disorders - phobia.

FINAL DIAGNOSIS

ICD 10

F 40 phobic Anxiety disorder.

MANAGEMENT

Pharmacological	-	T. Amitryptaline		1 - 0 - 1
		T. diazepam	5 mg	0 - 0 - 1

PSYCHOTHERAPY

Cognitive behavioural therapy was instituted.